

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-017673

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

4236

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Webster Groves	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 43 Sylvester Ave	
3. NAME OF DECEASED (Type or print) Ellen T. Greene		4. DATE OF DEATH Month April Day 15 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/18/1911
9. AGE (last birthday) 51	10. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Loomis, Nebraska	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Harry Tweedy		13b. MOTHER'S MAIDEN NAME Harriet Aukes	
14. NAME OF HUSBAND OR WIFE Shirley Greene		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None	
16. SOCIAL SECURITY NO. U None		17. INFORMANT Shirley Greene 43 Sylvester Ave (19)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of ovary</i> DUE TO (b) <i>metastases to abdominal cavity, pleural cavity</i> DUE TO (c) <i>175.0</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3+14/10
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. p.m.	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION 4-14-63		COUNTY STATE	
21. I attended the deceased from 2/11/63 to 4-14-63 and last saw her alive on 4-14-63		Death occurred at 4-15-63 9:00 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Joseph L. Lucido M.D.		22b. ADDRESS 1347 N. Grand	
22c. DATE SIGNED 4/16/63		22d. DATE SIGNED 4/16/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial (Auto)		23b. DATE 4/16/1963	
23c. NAME OF CEMETERY OR CREMATORY Merom Cemetery		23d. LOCATION (City, town, or county) Merom, Indiana	
24. FUNERAL DIRECTOR Alexander		25. DATE RECD. BY LOCAL REG. APR 16 1963	
26. REGISTRAR'S SIGNATURE R. Smith. M.D.		27. REGISTRAR'S SIGNATURE R. Smith. M.D.	

USE BLACK INK

OR

TYPEWRITER RIBBON

Dr. Joseph Lucido

Mo Theater Building

01 2-4838

4 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

John L. Alexander

Licensed Embalmer No. 1061

P. O. Address

Sullivan, Indiana

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.